| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155572 | A. BUILDING 00<br>B. WING | 12/20/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN HILLS HEALTH AND REHAB CENTER | 10352 N 600 E COUNTY LINE RD<br>DEMOTTE, IN 46310 |

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| F0000 | | F0000 | | |

This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00100554.

Complaint IN00100554-Substantiated. Federal/state deficiencies related to the allegations are cited at F323.

Survey dates: December 11, 12, 13, 14, 15, 16, and 20, 2011

Facility number: 000471
Provider number: 155572
AIM number: 100290390

Survey team:
Kelly Sizemore, RN-TC
Sheila Sizemore, RN
Regina Sanders, RN
(December 12, 13, 14, 15, 16, and 20, 2011)

Census bed type:
SNF/NF: 62
Residential: 14
Total: 76

Census payor type:
Medicare: 8
Medicaid: 49

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Other: 19<br>Total: 76<br><br>Sample: 15<br>Supplemental: 5<br>Residential: 5<br>Residential Supplemental: 2<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2<br><br>Quality review completed on December 22, 2011 by Bev Faulkner, RN | | | |

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| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | | | |
| | Based on record review and interview, the facility failed to notify residents' physicians in a timely manner related to a change in condition and medication refusal for 2 of 15 residents reviewed for physician notification in a total sample of 15. (Residents #6 and #64) | F0157 | **F 157**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of | 01/06/2012 |

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| | Findings include:<br><br>1. Resident #6's record was reviewed on 12/13/11 at 9:10 a.m. Resident #6's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and dementia.<br><br>Progress notes on the following dates and times indicated:<br><br>12/5/11 at 4:02 p.m., "...Resident lung sounds congestion and moist...Physician notified awaiting any new orders. No cough noted..."<br><br>12/6/11 2:01 a.m., "o2 (oxygen saturation) 89% on room air...Resident lungs sound congestion and moist. No cough noted. No oxygen has been ordered at the present time. Waiting to see if there are any new orders from (Physician's name)..."<br><br>12/7/11 at 4:26 a.m., "Writer alerted by QMA (Qualified Medication Aide), "(Resident's name) doesn't look right." Resident appeared dark around the mouth and eyes. Respirations are labored 28, o2 sat-88%..."<br><br>12/7/11 at 4:30 a.m., "Resident started on 2L (liters) via mask." | | correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>**Resident #6 had treatment ordered, initiated and completed per physician's orders.**<br>**Resident # 64 Staff abided by the resident's right to refuse medication. Resident discharged on date of last scheduled dose.**<br><br>**2) How the facility identified other residents:**<br>**All residents have the potential to be affected. December 2011 24 Hour Reports were reviewed for changes in condition and medication refusals to identify any other residents that may have been affected. Physicians were notified of identified changes and refusals.**<br><br>**3) Measures put into place/ System changes:**<br>**Licensed staff have been re-educated on the Physician Notification** | |

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| | 12/7/11 at 4:17 p.m., "Resident has not been on o2 (oxygen) during 6-2 shift o2 stats (sic) have stayed between 91 and 94%...Resident is very wheezy in the throat area and nose sounds like it is stuffed up..."<br><br>12/8/11 at 8:07 p.m. (3 days after first call to physician), "...Treatment plan/follow-up on treatment plan: Z-pack (antibiotic) and Depo-medrol (steroid) IM (intramuscular) x's (times) one dose..."<br><br>During an interview with the DoN (Director of Nursing) on 12/13/11 at 10:45 a.m., she indicated the physician should have been called again on 12/6/11 when there was no response from the physician.<br><br>2. Resident #64's record was reviewed on 12/15/11 at 1:30 p.m. Resident #64's diagnoses included, but were not limited to, hemiplegia, diabetes, and hypertension.<br><br>A physician's order, dated 12/2/11, indicated Furosemide (Lasix, a diuretic) 40 milligrams IM 1 time a day for 3 days.<br><br>A MAR for December 2011, indicated the Furosemide was refused on 12/3, 12/4, and 12/5. The resident never received the | | **Policy. DON or designee will audit the 24 Hour Reports to identify changes in condition, medication refusals, etc… and verify that physician notification has been completed. Audit of 24 Hour Reports will be completed a minimum of three times a week. Any identified discrepancies will be corrected.**<br><br>**4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for three months then quarterly for 3 months. Licensed Nurses identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| | medication.<br><br>The progress notes lacked documentation the physician was notified the resident's refusal of the medication for all three days.<br><br>During an interview on 12/15/11 at 11 a.m., with the DoN, she indicated the physician should have been notified if the resident refused 3 doses of a medication.<br><br>A facility policy titled "Administrative Physician Notification for Change in Condition," dated 8/2011 and received as current from the DoN on 12/14/11 at 12:15 p.m., indicated "Purpose...2. To ensure that medical care problems are communicated to the attending physician in a timely, efficient, and effective manner...General Guidelines:...2. The attending physician's responsibilities include: a. Responding in a timely manner to all calls from nurses..."<br><br>3.1-5(a)(2)<br>3.1-5(a)(3) | | | |

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| F0250 SS=D | The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>Based on record review and interview, the facility failed to ensure social services was notified for assistance with planning care related to behavior management and following the facility's policy for monthly behavior management meetings for 2 of 8 residents exhibiting behaviors in a sample of 15. (Residents #12 and #15)<br><br>Findings include:<br><br>1. Resident #12's record was reviewed on 12/13/11 at 9:00 a.m. Resident #12's diagnoses included, but were not limited to, Alzheimer's disease, senile dementia, and psychotic disorder with delusions.<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 9/24/11, indicated the resident had memory problems and was severely impaired for decision making. The quarterly MDS assessment indicated the resident had behaviors.<br><br>A behavior care plan, dated 6/23/11 and updated 11/17/11, indicated Resident #12 had periods of agitation and behaviors of yelling, cursing, hitting shoving and grabbing at staff. The following interventions were added into the resident's care plan: | F0250 | **F250**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>Social Services has been notified of the behaviors and PRN psychotropic use for resident #12 and #15<br><br>**2) How the facility identified other residents:**<br>All residents with a history of behavioral issues or receive PRN psychotropic medications, will have a documentation and MAR (Medication Administration Record) review of the past 30 days. Any identified episode of a behavior or use of a PRN psychotropic medication will be referred to the social | 01/06/2012 |

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| | 6/23/11, Remove resident from source of agitation and take her to less stimulating area away from other residents and the television when becoming agitated.<br>6/23/11, Offer resident a snack or drink.<br>6/23/11, Redirect her to an activity<br>6/23/11, Offer resident personal care, take to bathroom<br>11/07/11, Attempt to determine trigger and eliminate if possible<br>11/17/11, At first signs of agitation, provide resident with a familiar object for resident to hold<br>11/17/11, Explain all procedures prior to beginning<br>11/17/11, Speak with her in a calm manner<br><br>Review of the facility's progress notes indicated the following behaviors:<br>11/3/11 at 6:47 p.m., the resident had followed a male resident into his room. The progress note indicated the male resident yelled and hit her three times in the arm with a rolled newspaper.<br>11/18/11 at 5:00 p.m., the resident was in the dining room, approached another resident and smacked the resident across the face.<br><br>The above progress notes concerning the resident's behaviors were not entered into the assessments tab of behavior data collection tool in the electronic charting | | services director for further review and possible behavior plan update.<br><br>**3) Measures put into place/ System changes:**<br>The 24 hour report will be reviewed during the leadership team meeting. Episodes of observed undesirable behavior as well as PRN use of psychotropic medication use will be discussed by the team and recorded in the minutes of the meeting. The social services director will provide follow up documentation as needed. Licensed staff have been re-educated on appropriate documentation of undesirable behaviors. Behavior Team Meetings will be held monthly per facility policy. **Administrator or designee will audit 24 Hour Reports a minimum of three times per week to ensure that behavior documentation has been completed properly and Social Services notified.**<br><br>**4) How the corrective actions will be monitored:**<br>The results of the audits will be presented to the QA | |

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| | in the resident's chart.<br><br>The last behavior management team review indicated the date of 9/27/11.<br><br>The last care plan conference with the resident's family, concerning the resident's behaviors was 10/25/11.<br><br>During an interview on 12/13/11 at 11:00 a.m., the Social Services Director indicated she did not know about the resident's behaviors that were typed in the progress notes by the nurses. She indicated she looks at the behaviors that are typed on the behavior data collection tool in the assessment tab. She indicated the nurses are supposed to fill out the behavior data collection tool. She indicated she had not gotten around to having a behavior management meeting for the residents on behavior management in November as she was supposed to.<br><br>An undated facility policy, titled "Behavior Management Team Review," provided by the Social Service Director on 11:40 a.m., indicated, "...The Behavior Management Team shall: 1. Review and discuss the efficacy of each resident's Behavior Plan on a monthly basis during the scheduled Behavior Management meeting. 2. Designated team members shall complete the Behavior Management | | Committee monthly for three months and then quarterly. Staff identified as being non-compliant with appropriate documentation will be counseled.<br><br>**5) Date of compliance:** 1/6/2012 | |

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| | Team....2. Maintain the completed Behavior Management Team Review form in the resident's medical record...."<br><br>2. Resident #15's record was reviewed on 12/15/11 at 9:55 a.m. Resident #15's diagnoses included, anxiety, bi-polar disease, and unspecified psychosis.<br><br>An annual MDS assessment, dated 10/26/11, indicated the resident was alert and oriented. The annual MDS assessment indicated the resident had verbal behavioral symptoms directed towards others.<br><br>Review of the resident's record indicated the following care plans:<br>6/8/11, revised 6/9/11, Disruptive behavior in groups and high stimulus activities at times will become upset and begin yelling out inappropriately at other residents, and has a history of striking out at other residents, "1. administer meds as ordered 2. convey acceptance of resident and provide repeated honest appraisals of resident's strengths to resident 3. discuss feelings and options of appropriate channeling of these feeling with resident 4. encourage resident to take active social role within facility. 4. encourage self-control and problem solving skills including awareness of behavior, directing/redirecting energies into | | | |

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| | stress-reducing activities and behaviors<br>5. monitor for changes in mood"<br><br>6/10/11, revised 6/10/11, yells out, curses, makes non-threatening statements when upset "1. provide psych care as needed, involve guardian as needed and give meds as ordered per nursing staff 2. explain his agitation may scare others 3. Notify SS (social service) of any mood/behavior indicators 4. place on 15 minute checks as needed 5. upodate (sic) MD (Medical Doctor) of increased behavior/agitation of new worsening behaviors 6. take the resident to a quiet place but do not isolate and allow him to calm 7. observe the resident for aggressive behavior red face, yelling pointing his finger, increased tone of voice 8. provide 1 on 1 as needed"<br><br>6/10/11, revised 10/31/11, yelled at another resident and their family in the dining room, has a history of physical aggression. Has told another resident "I want to kill you" 1. provide an alternate place to eat if the resident wishes 2. ask if he would like to eat in his meal in another area of the facility 3. sit resident away from residents who may annoy this resident 4. take to a quiet place and allow him to calm 5. ask the resident to use other door when exiting the dining room 6. explain the importance of respecting others 7. immediately separate the | | | |

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| | residents if verbal or physical altercation occurs."<br><br>The last documented behavior management team review was dated 9/27/11.<br><br>A progress note, dated 11/29/11 at 1:15 p.m., indicated "Ativan (anti-anxiety) -give 0.5mg (milligrams) PRN (as necessary) : resident is calm and ate lunch without incident."<br><br>During an interview on 12/15/11 at 10:55 a.m., the Social Service Director indicated she did not know why the resident received the Ativan. She indicated she looks only in the assessment tab. She indicated she only goes into the progress notes if she in completing a MDS assessment. She indicated the nurses were inserviced to document on the behavior data collection tool located in the assessment tab. The Social Service Director indicated "it was a problem."<br><br>3.1-34(a) | | | |

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| F0282 SS=D | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>Based on record review and interview, the facility failed to follow physician's orders related to laboratory testing for 1 of 15 residents reviewed for laboratory tests in a sample of 15. (Resident #3)<br><br>Findings include:<br><br>1. Resident #3's record was reviewed on 12/12/11 at 11 a.m. Resident #3's diagnoses included, but were not limited to, aftercare following organ transplant, hypertension, and hypothyroidism.<br><br>a. A physician's order, dated 11/10/11, indicated BK virus DNA quant (test on immunosuppressed individuals to check for viral DNA presence, useful in establishing the cause of allograft rejection) every month.<br><br>The lab results, dated 11/11/11, indicated the BK virus DNA quant was canceled.<br><br>During an interview with the Director of Nursing (DoN), on 12/15/11 at 8:40 a.m., she indicated the laboratory had drawn the BK virus DNA quant on Friday November 11, 2011 but it was not picked up from the facility until Monday | F0282 | **F 282**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>**Resident #3 Transplant Team notified of the labs that were not drawn. Orders were received to decrease the frequency of the lab draws**<br><br>**2) How the facility identified other residents:**<br>**Labs scheduled for the past 30 Days have been audited to ensure that all have been obtained.**<br>**The physicians will be notified of any discrepancies.**<br><br>**3) Measures put into place/ System changes:** | 01/06/2012 |

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| | 155572 | A. BUILDING 00<br>B. WING | 12/20/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN HILLS HEALTH AND REHAB CENTER | 10352 N 600 E COUNTY LINE RD<br>DEMOTTE, IN 46310 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | November 13. She indicated she called the laboratory and they told her that the 11/11 test was canceled. The laboratory had called and spoke with LPN #1 on 11/17 and notified her the "bk virus dna was canceled since repeat analysis indicated pcr inhibitors in the specimen. New specimen should be sent."<br><br>The resident's record lacked documentation of a new specimen being sent.<br><br>During an interview with the DoN, on 12/15/11 at 8:50 a.m., she indicated a new specimen was not obtained.<br><br>b. A physician's order, dated 11/10/11, indicated Mycophenolic acid level 12 hours after last dose every week on Monday and Wednesday.<br><br>A physician's order, dated 10/19/11, indicated the resident was on Myfortic (Mycophenolate Sodium) (immunosuppressant) 720 milligrams by mouth every 12 hours daily.<br><br>A Daily Specimen Collection Report, dated 11/11/11, had the Mycophenolic acid level listed to be drawn that day.<br><br>A Specimen Collection List, dated 11/11/11, had an area for test add-on's and | | **DON or designee will audit new lab orders a minimum of three times a week and verify that they have been properly ordered**<br>**DON or designee will audit scheduled lab tests a minimum of three times per week to ensure that they have been obtained per orders.**<br>**Licensed Nurses have been re-educated on the process for ordering lab tests.**<br><br>**4) How the corrective actions will be monitored: Results of the audits will be presented to the Quality Assurance Committee monthly for three months and then quarterly for three months. Licensed Nurses that are identified as non-compliant will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| | future orders. It lacked documentation of the Mycophenolic acid level to be drawn every week on Monday and Wednesday.<br><br>The resident's record indicated a Mycophenolic acid level was drawn on 11/11/11 and was within normal range. The record lacked any further Mycophenolic acid levels drawn after 11/11/11.<br><br>During an interview with the DoN, on 12/14/11 at 1:30 p.m., she indicated the lab was drawn on 11/11/11 but none after that.<br><br>3.1-35(g)(2) | | | |

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| F0309 SS=D | Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | | | |
| | Based on record review and interview, the facility failed to provide the necessary care and services to residents in the facility, related to assessing an AV (arterio-venous) shunt (dialysis access) for 1 of 1 resident who received dialysis (Resident #63) in a sample of 15. (Resident #63)<br><br>Findings include:<br><br>1. Resident #63's record was reviewed on 12/14/11 at 10 a.m. The resident's diagnoses included, but were not limited to, renal failure and diabetes mellitus.<br><br>A hospital, History and Physical, dated 09/26/11, indicated the resident had a left (arm) AV shunt.<br><br>A hospital, discharge summary, dictated 11/09/11, indicated the resident had a left (arm) AV shunt.<br><br>Readmission Nursing Observations forms, dated 09/28/11 and 11/08/11, lacked documentation to indicate the resident had a left arm AV shunt. | F0309 | **F309**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>**Resident # 63 Upon readmission to the facility the left A/V shunt was added to his assessment and appropriate orders added to physician's orders.**<br>**Location and days of dialysis were added to chart.**<br><br>**Resident #6 PRN medication was administered per orders by the QMA with authorization from the licensed nurse.**<br><br>**2) How the facility identified other residents:** | 01/06/2012 |

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| | The resident's current physician's orders, printed on 12/15/11, lacked documentation the resident had a left arm AV shunt and was receiving dialysis.<br><br>A care plan, dated 04/11/11, indicated the resident received dialysis due to end stage renal disease. The interventions included, dialysis per orders.<br><br>There was a lack of documentation on the resident's Nursing Progress Notes, dated 10/20/11 through 12/14/11 to indicate the resident's left arm AV shunt had been assessed.<br><br>There was a lack of documentation on the resident's Medication and Treatment Administration Records, dated 10/11, 11/11, and 12/11 to indicate the resident's left arm AV shunt had been assessed.<br><br>During an interview on 12/15/11 at 8:50 a.m., the RN Nursing Consultant indicated there was no documentation of the Left arm AV shunt on the Readmission Nursing Observations on 09/28/11 and 11/08/11. She indicated she could not find where the left arm AV shunt had been assessed by the facility.<br><br>During an interview on 12/15/11 at 11:10 a.m., the Dialysis Clinical Manager, from | | **All residents have the potential to be affected. All residents that receive dialysis were reviewed to ensure that their dialysis access site was clearly identified in their medical record along with appropriate orders. Location and days of dialysis were added to charts.**<br>**PRN medications administer for December were reviewed to ensure that they were properly documented and needed assessments completed. Deficiencies corrected as identified.**<br><br>**3) Measures put into place/ System changes:**<br>**DON or designee will audit PRN medications a minimum of three times per week and observe for appropriate documentation for time of administration and follow up documentation .**<br>**Medical Records or designee will audit admission/re-admission charts within 72 hours to ensure that all pertinent information regarding dialysis are present. Any** | |

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| | the dialysis center where the resident was receiving dialysis, indicated the AV shunt should be assessed at least one time a shift. She indicated the AV shunt especially needs assessed after dialysis to ensure there is no bleeding from the shunt.<br><br>During an interview on 12/15/11 at 2:15 p.m., the RN Nursing Consultant indicated the facility did not have a policy for dialysis.<br><br>3.1-37(a) | | **discrepancies will be corrected immediately. Licensed Nurses have been re-educated on proper completion of admission documentation.**<br><br>**4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months. Nurses identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| F0323 SS=D | The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | | | |
| | Based on observations, record review, and interview, the facility failed to ensure interventions were put into place to prevent further falls for 3 of 11 residents with falls in a total sample of 15. (Residents B, C and D)<br><br>Findings include:<br><br>1. Resident B's record was reviewed on 12/12/11 at 8:55 a.m. Resident B's diagnoses included, but were not limited to, stroke, debility, and malaise and fatigue.<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 10/13/11, indicated the resident was alert and oriented. The MDS assessment indicated the resident required extensive assist of one staff member for transfers, bed mobility, locomotion, toileting, and personal hygiene. The MDS assessment indicated Resident B had falls since admission into the facility and since the last assessment.<br><br>A fall care plan, dated 2/1/11 and revised on 12/12/11 by the nurse consultant, indicated "(Resident's name) needs a safe environment with adequate lighting, | F0323 | **F323**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified: Resident B Alarms had sounded with both falls, the alarms alerted staff to the area. Floor mat placed on the floor next to his bed.**<br><br>**Resident C Alarm was turned on by staff.**<br><br>**Resident D Alarm was turned on by staff.**<br><br>**2) How the facility identified other residents:**<br>**All residents that have had a fall have the potential to be affected. Falls for** | 01/06/2012 |

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| | environment as clear and uncluttered as possible, side rails per orders 2/1/11, provide (Resident's name) with needed assistance for all ADLS (activities of daily living) 2/1/11, alarms to bed, w/c (wheelchair) on outside of room door and bathroom door 11/3/11, be sure that (Resident's name) call light is within reach and encourage (Resident's name) to use it for assistance as needed. remind him as needed to use call light 8/8/11, AFO (splint) to right leg when up 2/17/11, provide restorative therapy program to maintain or improve functional status, 8/8/11, revised 12/12/11, Resident to have a scheduled toileting program 10/5/11, encourage (Resident's name) to participate in activities and to stay on the unit 10/4/11, Therapy to eval and treat as indicated 12/12/11, keep personal items within reach 5/22/11, make sure shower chair wheels are locked 6/27/11."<br><br>A fall risk assessment, dated 4/11/11, indicated a score of 15, placing the resident was at high risk for falls.<br><br>A fall progress note, dated 11/28/11 Late Entry at 12:44 p.m., indicated "Found resident laying on his right side with his right arm behind him at 1205 (12:05 p.m.). Wheelchair was in front of his door. There was a pool of blood under | | **December have been reviewed to ensure that appropriate interventions have been added after each fall.**<br><br>**3) Measures put into place/ System changes:**<br>**Licensed Nurses have been re-educated on fall protocol, how to identify root cause and the importance of adding a new intervention to aid in preventing further falls.**<br>**Staff educated on the importance of making sure that alarms are in place and functioning. Nursing Assistants document placement and function of alarms every shift.**<br>**Licensed Nurses will make random checks on placement and function of alarms on each shift daily.**<br>**Interdisciplinary Team will review all falls within 72 hours of occurrence to ensure that the root cause has been identified and an appropriate intervention implemented.**<br>**DON or designee will audit all falls to ensure that a new intervention has been implemented.** | |

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| | the head the size of a dinner plate. Resident had a small laceration, with a hematoma the size of a large marble starting to become visible on resident's right side of head...Fall not witnessed..."<br><br>Review of a post fall investigation, dated 11/29/11, indicated "Root cause of fall: Attempted to stand without assistance and fell. additional interventions: Sent for evaluation. Continue current interventions." The internal factors possibly related to fall were forgets to call for assistance, lack of safety awareness and history of wandering were circled. It lacked documentation if the alarms were in place at the time of the fall.<br><br>During an interview on 12/12/11 at 3:10 p.m., the DoN indicated there were no new interventions added to prevent further falls on 11/28/11.<br><br>A fall progress note, dated 12/3/11 at 11:55 a.m., indicated "Patient laying on floor in room on right side..."<br><br>A post fall investigation, dated 12/5/11, indicated "Root cause of fall: resident failed to turn on call light for assistance attempted to get self up out of bed and fell incontinent. Needed to use the bathroom. Additional interventions: toileting every 2 hours, remind resident to use call | | **4) How the corrective actions will be monitored: Results of Audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Staff that are identified as being non-compliant in making sure that alarms and safety measures are not in place will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| | lights...." The internal factors possibly related to fall were lack of safety awareness and forgets to call for assistance. It lacked documentation if the alarms were in place at the time of the fall.<br><br>The additional interventions for the toileting scheduled and the remind resident to use the call light had been placed on the care plan on 10/5/11 and 8/8/11.<br><br>A physician's order, dated 12/09/11, indicated physical and occupational therapy to re-evaluate and treat.<br><br>During an interview on 12/13/11 at 8:40 p.m., the Therapy Rehab Manager indicated the family had spoken to the doctor and got the therapy order.<br><br>During an interview on 12/14/11 at 8:50 a.m., with the Nurse Consultant and the DoN, the Nurse Consultant indicated the resident was difficult due to impulsiveness and not being able to control the impulsiveness. The Nurse Consultant indicated there was nothing else but to provide one on one care. The DoN indicated the facility had not put in new interventions in place after the fall on 11/28/11. | | | |

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| | Review of the facility "Fall Risk and Post Fall Investigation policy," dated 8/09, indicated "...4. Complete a Fall Investigation a. Implement interventions to prevent further falls. Update care plan with new intervention...."<br>2. During an observation on 12/11/11 at 4:13 p.m., with LPN #1, Resident #C was laying in bed. The sensor bed alarm was not turned on. LPN #1 acknowledged the sensor bed alarm was not turned on at the time of the observation.<br><br>Resident #C's record was reviewed on 12/15/11 at 9:40 p.m. The resident's diagnoses included, but were not limited to dementia and hypertension.<br><br>The Admission/5 Day MDS (Minimum Data Set) assessment, dated 10/31/11, indicated the resident had falls prior to being admitted into the facility.<br><br>The care plan, dated 12/05/11, indicated the resident was a potential for falls. The interventions included, an alarm to the bed and the wheelchair.<br><br>The Fall Risk Evaluation, dated 12/02/11, indicated the resident was a high risk for falls with a score of 17. The evaluation indicated the resident had two or more falls in one month. | | | |

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| | The Personal Alarm Assessment, dated 12/05/11, indicated the resident tries to get out of bed unsafely and tries to stand, transfer, and walk alone. The assessment indicated the resident required a personal alarm.<br><br>3. During an observation on 12/11/11 at 6:41 p.m., with RN #2 present, Resident #D stood up from her wheelchair, which was sitting by the Nurses' Station, and ambulated 1/2 way to the Nurses' Station. The resident's wheelchair alarm did not activate.<br><br>During an interview at the time of the observation, RN #2 indicated the resident's chair alarm was not turned on.<br><br>Resident # D's record was reviewed on 12/12/11 at 2:55 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and dementia.<br><br>The resident's Quarterly MDS assessment, dated 10/25/11, indicated the resident had two or more falls without injury since the last MDS assessment had been completed.<br><br>The care plan, dated 02/15/11, indicated the resident was a risk for falls, related to a history of falls. The interventions included an alarm to the resident's chair. | | | |

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| | An Interdisciplinary Team note, dated 11/03/11, indicated to continue with the alarm to the resident's bed and wheelchair.<br><br>The Progress Notes, dated 11/26/11 at 5:37 p.m., indicated the resident had slid out of the wheelchair in the dining room.<br><br>This Federal Tag relates to Complaint IN00100554.<br><br>3.1-45(a)(2) | | | |

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| F0329 SS=D | Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | | | |
| | Based on record review and interview, the facility failed to ensure interventions were attempted prior to giving a PRN (as needed) antianxiety medication for 1 of 5 residents reviewed for PRN antianxiety medications in a total sample of 15. (Resident #19)<br><br>Findings include:<br><br>1. Resident #19's record was reviewed on 12/15/11 at 9:20 a.m. Resident #19's diagnoses included, but were not limited to, Parkinson's disease, congestive heart failure, and anxiety. | F0329 | **F329**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified: Resident #19 had no adverse** | 01/06/2012 |

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| | 155572 | A. BUILDING 00<br>B. WING | 12/20/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN HILLS HEALTH AND REHAB CENTER | 10352 N 600 E COUNTY LINE RD<br>DEMOTTE, IN 46310 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | A physician's order, dated 10/4/11, indicated Xanax (antianxiety medication) 0.25 milligrams by mouth 2 times a day as needed (prn) for agitation.<br><br>A November 2011 MAR (Medication Administration Record) indicated Xanax was given on 11/6 and 11/25.<br><br>A progress note, dated 11/6/11 at 2:09 a.m., indicated Xanax was given due to "...nervious (sic) resident. shaking bed rail," but lacked documentation of interventions tried prior to giving the Xanax.<br><br>A progress note, dated 11/25/11 at 8:05 p.m., indicated Xanax was given but lacked any interventions tried prior to giving the Xanax.<br><br>A December 2011 MAR indicated Xanax was given on 12/10.<br><br>A progress note, dated 12/10/11 at 9:32 p.m., indicated "...one prn 0.25 xanax given for agitation. resident has been up and down from bed to wheelchair and back for last 45 minutes. will get up in wheelchair and want back into bed within 5 to 10 minutes and same when in bed to wheelchair..." The progress note lacked documentation of any interventions tried | | **effects from the administration of Xanax.**<br><br>**2) How the facility identified other residents:**<br>**All residents that receive PRN psychotropic medications have the potential to be affected. Residents that received PRN psychotropic medications in the month of December have been reviewed to ensure that documentation of non-pharmaceutical interventions were documented. All were reviewed for any adverse effects from the administration of the prn psychotropic medications.**<br><br>**3) Measures put into place/ System changes:**<br>**Licensed Nurses re-educated on proper documentation for use of PRN psychotropic medications.**<br>**DON or designee will audit PRN psychotropic medication use a minimum of three times per week to ensure that interventions prior to administration of PRN psychotropic** | |

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| | prior to giving the Xanax.<br><br>A care plan, "Resident receives antianxiety medications as needed," dated 6/23/11, indicated "...Interventions...staff to provide other interventions prior to giving antianxiety medication..."<br><br>During an interview with the RN Nursing Consultant, on 12/15/11 at 10:45 a.m., she indicated the nurses should write in the progress note about behaviors and interventions tried before giving a PRN medication.<br><br>During an interview with the RN Nursing Consultant, on 12/15/11 at 10:55 a.m., she indicated there were not any interventions documented prior to the Xanax being given on those dates.<br><br>3.1-48(a)(4) | | **medication have been documented.**<br><br>**4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Nurses identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| F0354 SS=C | Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. | | | |
| | Based on record review and interview, the facility failed to have a RN present in the building for at least 8 consecutive hours a day for 2 days out of 37 days. This had the potential to affect 62 of 62 residents.<br><br>Findings include:<br><br>1. Nursing Staff schedules provided by the DoN (Director of Nursing) for 11/5/11 through 12/11/11, indicated there was no RN coverage for 8 hours a day for 11/5/11 and 11/6/11.<br><br>During an interview with the DoN, on 12/13/11 at 10:30 a.m., she indicated she is running ads consistently to hire RN's. She indicated they are struggling to keep RN's and are doing everything they can.<br><br>3.1-17(b)(3) | F0354 | **F354**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>**An additional RN was hired the week prior to survey.**<br><br>**2) How the facility identified other residents:**<br>**No residents were affected.**<br><br>**3) Measures put into place/ System changes:** | 01/06/2012 |

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| | | | **Facility will continue to advertise and make every effort to hire and maintain adequate number of RN to have RN coverage for eight hours a day seven days per week.**<br><br>**4) How the corrective actions will be monitored: Status of RN coverage and strategies being utilized to obtain adequate RN coverage will be presented to the Quality Assurance Committee monthly for three months and quarterly until adequate RN staffing is achieved and maintained.**<br><br>**5) Date of compliance:**<br>**January 6, 2012** | |

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| F0385 SS=D | A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.<br><br>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.<br><br>Based on record review and interview, the facility failed to ensure a physician provided medical care to a resident related to the resident's physician not responding to the facility staff phone call about a change in condition of a resident, for 1 of 15 residents reviewed for physician responding for medical care in a total sample of 15. (Resident #6)<br><br>Findings include:<br><br>1. Resident #6's record was reviewed on 12/13/11 at 9:10 a.m. Resident #6's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and dementia.<br><br>Progress notes on the following dates and times indicated:<br><br>12/5/11 at 4:02 p.m., "...Resident lung sounds congestion and moist...Physician notified awaiting any new orders. No cough noted..." | F0385 | **F385**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified: Resident #6 Treatment was obtained, initiated and completed per physician's orders.**<br><br>**2) How the facility identified other residents:**<br>**All residents have the potential to be affected. 24 Hour Reports for December have been reviewed for changes of condition,** | 01/06/2012 |

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| | 12/6/11 2:01 a.m., "o2 (oxygen saturation) 89% on room air...Resident lungs sound congestion and moist. No cough noted. No oxygen has been ordered at the present time. Waiting to see if there are any new orders from (Physician's name)..."<br><br>12/7/11 at 4:26 a.m., "Writer alerted by QMA (Qualified Medication Aide), "(Resident's name) doesn't look right." Resident appeared dark around the mouth and eyes. Respirations are labored 28, o2 sat-88%..."<br><br>12/7/11 at 4:30 a.m., "Resident started on 2L (liters) via mask."<br><br>12/7/11 at 4:17 p.m., "Resident has not been on o2 (oxygen) during 6-2 shift o2 stats (sic) have stayed between 91 and 94%...Resident is very wheezy in the throat area and nose sounds like it is stuffed up..."<br><br>12/8/11 at 8:07 p.m. (3 days after first call to the physician), "...Treatment plan/follow-up on treatment plan: Z-pack (antibiotic) and Depo-medrol (steroid) IM (intramuscular) x's (times) one dose..."<br><br>During an interview with the DoN (Director of Nursing) on 12/13/11 at | | **physician notification and timeliness of physician response. Letter sent to facility physicians informing them of the expectation of response time to changes in condition.**<br><br>**3) Measures put into place/ System changes:**<br>**Staff re-educated on the Change of Condition Policy. Physicians notified that a timely response is required for all changes in condition.**<br>**DON or designee will audit 24 Hour Reports a minimum of three times per week Changes in condition will be identified and physician notification and response will be verified.**<br><br>**4) How the corrective actions will be monitored:**<br>**Results from audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Nurses identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance:** | |

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| | 10:45 a.m., she indicated the physician did not respond until 12/8/11 to the condition change notification of 12/5/11.<br><br>3.1-22(a)<br>3.1-22(a)(1)<br>3.1-22(a)(2) | | **January 6, 2012** | |

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| F0425 SS=D | The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. | | | |
| | Based on record review and interview, the facility failed to ensure an adequate amount of medication was received from the pharmacy, related to 2 residents not receiving a dose of medication as ordered by the physician for 2 of 15 residents reviewed for receiving medications in a sample of 15. (Residents #15 and #21)<br><br>Findings include:<br><br>1. Resident #15's record was reviewed on 12/15/11 at 9:55 a.m. Resident #15's diagnoses included, but were not limited to, bi-polar disease and anxiety.<br><br>A physician's order, dated 8/4/11, indicated "Zyprexa (antipsychotic) 2.5 mg | F0425 | **F425**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>**Resident #15 Physician notified of missed dose of Zyprexa.** | 01/06/2012 |

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| | (milligrams) tablet orally every morning"<br><br>Review of progress note, dated 10/23/11, indicated "Zyprexa-give zyprexa 2.5 mg orally everyday: drug unavailable"<br><br>An interview on 12/15/11 at 8:40 a.m., the DoN indicated the resident had not received the Zyprexa.<br><br>2. Resident #21's record was reviewed on 12/15/11 at 1:00 p.m. Resident #21's diagnoses included, but were not limited to, anxiety, dementia with behavior disturbance, and hypertension.<br><br>The November 2011, physician's orders indicated, "Prednisone 5 mg tablet orally once a day."<br><br>A progress note, dated 11/27/11, indicated the resident did not receive the daily dose of 5 mg of prednisone due to the medication was not in from the pharmacy.<br><br>During an interview on 12/16/11 at 8:40 a.m., the DoN indicated she did not know why the medication was not available.<br><br>3.1-25(a) | | **Resident # 21 Physician notified of missed dose of Prednisone**<br>**2) How the facility identified other residents:**<br>**All residents have the potential to be affected. Audit of medication and treatment carts was conducted to ensure that supply of each medication was present. All medications that needed to be reordered have been reordered.**<br><br>**3) Measures put into place/ System changes:**<br>**Licensed Nurses and QMAs re-educated on the importance of reordering medications timely and administering all medications as ordered and the proper manner to handle missing doses of medication.**<br><br>**DON or designee will audit MARs a minimum of three times per week to ensure that all medications have been administered as ordered.**<br><br>**4) How the corrective actions will be monitored:** | |

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| | | | **Results of audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Nurses that are identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| F0505 SS=D | The facility must promptly notify the attending physician of the findings. | | | |
| | Based on record review and interview, the facility failed to promptly notify residents' physicians of laboratory results for 1 of 15 residents reviewed for laboratory results and physician's notification in a sample of 15. (Residents #5)<br><br>Findings include:<br><br>Resident #5's record was reviewed on 12/13/11 at 1:40 p.m. Resident #5's diagnoses included, but were not limited to, hypercholesterolemia, spontaneous ecchymoses, and anemia.<br><br>The December 2011, physician's orders (recap), indicated "digoxin level, cholesterol, CBC (complete blood count), BMP (basic metabolic profile),SGOT (liver function blood test), SGPT (liver function blood test), liver function, every 3 months."<br><br>Resident #5's electronic record and paper record lacked documentation the facility had notified the resident's physician of the abnormal lab results for August 2011.<br><br>During an interview on 12/15/11 at 2:25 p.m., the Nurses Consultant indicated the lab results "were in the portal" (a link to access laboratory results from the facility) | F0505 | **F505**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified: Resident # 5 Results were obtained, physician notified of results and no new orders were given.**<br><br>**2) How the facility identified other residents:**<br>**All residents that have labs ordered have the potential to be affected.**<br><br>**3) Measures put into place/ System changes:**<br>**Licensed Nurses have been re-educated on the proper procedure for lab result process.**<br>**All ordered lab tests will be reviewed and charts audited** | 01/06/2012 |

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| | and she had called the lab. She indicated the facility had not notified the physician of the lab results but the laboratory had sent the physician the results.<br><br>3.1-49(f)(2) | | **to ensure that all results were received and notified to the physician.**<br>**DON or designee will audit ordered labs a minimum of three times per week to ensure that physicians have been notified of results.**<br>**Any discrepancies will be corrected immediately.**<br><br>**4) How the corrective actions will be monitored:**<br>**Results of audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Staff that are identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance:**<br>**January 6, 2012** | |

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| F0507 SS=D | The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. | | | |
| | Based on record review and interview, the facility failed to ensure residents' laboratory reports were in the residents' individual records for 2 of 15 residents reviewed for labs in a sample of 15. (Residents #5 and #21)<br><br>Findings include:<br><br>1. Resident #5's record was reviewed on 12/13/11 at 1:40 p.m. Resident #5's diagnoses included, but were not limited to, hypercholesterolemia, spontaneous ecchymoses, and anemia.<br><br>The December 2011, physician's orders (recap), indicated "Digoxin level, cholesterol, CBC (complete blood count), BMP (basic metabolic profile),SGOT (liver function blood test), SGPT (liver function blood test), liver function, every 3 months."<br><br>Resident #5's electronic record and paper record lacked documentation of the lab results for August 2011.<br><br>During an interview on 12/15/11 at 2:25 p.m., the Nurses Consultant indicated the lab results "were in the portal" (a link to access laboratory results from the | F0507 | **F507**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>**Resident # 5 Copy of results placed on chart.**<br>**Resident #21 Copy of results placed on chart.**<br><br>**2) How the facility identified other residents:**<br>**All residents have the potential to be affected.**<br><br>**3) Measures put into place/ System changes:**<br>**Licensed staff have been re-educated on the process for handling lab results.**<br>**DON or designee will audit lab orders and results a minimum of three times per** | 01/06/2012 |

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| | 155572 | A. BUILDING 00<br>B. WING | 12/20/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN HILLS HEALTH AND REHAB CENTER | 10352 N 600 E COUNTY LINE RD<br>DEMOTTE, IN 46310 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | facility).<br><br>2. Resident #21's record was reviewed on 12/15/11 at 1:00 p.m. Resident #21's diagnoses included, but were not limited to dementia with behavior disturbance and hypertension.<br><br>A physician's order indicated a pre albumin level on 12/14/11.<br><br>The resident's electronic record and paper record lacked documentation of the results of the pre albumin level.<br><br>During an interview on 12/15/11 at 3:05 p.m., the DoN indicated the pre albumin results were not posted in the portal. The DoN indicated she called the lab and the lab had the results but had a problem getting the results in the portal. She indicated "there had been a problem and they were in the process of fixing it."<br><br>3.1-49(f)(4) | | **week. Audit of past 30 days of labs has been completed to ensure that results are present in the medical record.**<br><br>**4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months. Nurses identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| F0513 SS=D | The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.<br>Based on record review and interview, the facility failed to ensure a resident's x-rays were in the resident's clinical records for 1 of 15 residents reviewed for x-ray results in a sample of 15. (Residents B)<br><br>Findings include:<br><br>1. Resident B's record was reviewed on 12/12/11 at 8:55 a.m. Resident B's diagnoses included, but were not limited to, stroke, debility, and malaise and fatigue.<br><br>Resident B's record indicated the resident had fallen on 2/23/11, 4/14/11, and 11/28/11. The record indicated the resident had been sent to the hospital for evaluation and treatment on the above dates.<br><br>The resident's electronic record and paper record lacked documentation of the results of the CT (computerized tomography)-scans completed at the hospital for 2/23/11, 4/14/11, and 11/28/11.<br><br>During an interview on 12/12/11 at 3:10 p.m., the Director of Nursing indicated the CT-scans were not in the resident's | F0513 | **F513**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified: Resident B CT scans were obtained from the hospital and placed in his medical record.**<br><br>**2) How the facility identified other residents:**<br>**All residents have the potential to be affected. Residents that were sent out of the facility for assessment during December have had charts reviewed, diagnostic results that were not found in charts have been requested from the hospitals.**<br><br>**3) Measures put into place/** | 01/06/2012 |

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| | record.<br><br>The CT-scans were faxed from the hospitals on 12/13/11 at 8:51 a.m., and 9:00 a.m., and were received on 12/13/11 at 9:15 a.m., from Medical Records.<br><br>3.1-49(j)(4) | | **System changes:**<br>**Licensed Nurses have been re-educated on the need to request copies of lab and diagnostic results when residents are sent out to the hospital for evaluation.**<br>**Medical Records will request copies of lab and diagnostic results from the hospital within 72 hours of trip to the hospital. DON or designee will audit for lab and diagnostic results weekly for residents that have been sent out of the facility for evaluation or testing.**<br><br>**4) How the corrective actions will be monitored:**<br>**Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months. Nurses identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance:**<br>**January 6, 2012** | |

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| F0514 SS=D | The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. | | | |
| | Based on record review and interview, the facility failed to ensure medical records were complete and accurate related to, physicians orders, hospital transfers, central lines (surgically placed IV) and AV (Arterio-venous) shunt (dialysis access), for 3 of 15 residents reviewed for complete and accurate medical records. (Residents C, #15, and #63)<br><br>Findings include:<br><br>1. Resident #15's record was reviewed on 12/15/11 at 9:55 a.m. Resident #15's diagnoses included, but were not limited to, anxiety and bipolar.<br><br>A physician's PRN (as necessary) medication order, dated 11/7/11, indicated "Ativan (anti-anxiety medication)...give 0.5 mg (milligrams) prn for anxiety." There was a lack of documentation of how often the as needed Ativan could be administered. | F0514 | **F514**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified: Resident # 15 Order for PRN Ativan has been clarified to include the frequency of use.**<br><br>**Resident # 63 Left AV shunt added to chart when he was readmitted. Also upon readmission his central line was added to the chart. Copies of documentation about the removal of resident's IJ** | 01/06/2012 |

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| | During an interview on 12/16/11 at 8:40 a.m., the Director of Nursing (DoN) indicated she had "corrected the order for the Ativan." | | **catheter placed in his medical record.**<br><br>**Resident C Late entry made by responsible nurse regarding her assessment and sending resident to the emergency room.**<br><br>**2) How the facility identified other residents:**<br>**All residents have the potential to be affected. Pharmacy audited resident orders for December. Orders clarified as indicated.**<br><br>**Residents admitted in December with IV access or receiving dialysis charts reviewed for appropriate orders. Identified issues corrected.**<br><br>**3) Measures put into place/ System changes:**<br>**Licensed Nurses re-educated on Admission assessments, Physicians orders, change in condition and transfer documentation. DON or designee will review 24 Hour reports a minimum of three times per week to identify residents with new** | |

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| | 2. Resident #63's record was reviewed on 12/14/11 at 10 a.m. The resident's diagnoses included, but were not limited to, renal failure and diabetes mellitus.<br><br>a) A hospital, History and Physical, dated 09/26/11, indicated the resident had a left (arm) AV shunt.<br><br>A hospital, discharge summary, dictated 11/09/11, indicated the resident had a left (arm) AV shunt.<br><br>Readmission Nursing Observations | | **orders, transfers or admission/readmission to ensure that orders are complete, transfer and and admission/readmission documentation is complete. Any deficiencies identified will be corrected.**<br><br>**4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months. Nurses identified as being non-compliant will be counseled.**<br><br>**5) Date of compliance: January 6, 2012** | |

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| | forms, dated 09/28/11 and 11/08/11, lacked documentation to indicate the resident had a left arm AV shunt.<br><br>The resident's current physician's orders, printed on 12/15/11, lacked documentation the resident had a left arm AV shunt and was receiving dialysis.<br><br>A care plan, dated 04/11/11, indicated the resident received dialysis due to end stage renal disease. The interventions included, dialysis per orders.<br><br>During an interview on 12/15/11 at 8:50 a.m., the RN Nursing Consultant indicated there was no documentation of the Left arm AV shunt on the Readmission Nursing Observations on 09/28/11 and 11/08/11.<br><br>b) A pharmacy, "Midline Catheter-Physician Order Sheet", undated, indicated the resident had a two lumen midline catheter.<br><br>The Readmission Nursing Observations, dated 09/28/11, lacked documentation to indicate the resident had a central line.<br><br>The Progress Notes, dated 09/28/11 through 10/21/11, lacked documentation to indicate the resident had a central line. | | | |

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| | The Medication Administration Record, dated 10/11, indicated to assess the central line site every shift and to change the dressing every week.<br><br>A Physician's Order, dated 10/20/11 indicated, "D/C (discontinue) PICC (peripherally inserted central catheter) line.<br><br>There was a lack of documentation in the resident's Progress Notes after 10/20/11 to indicate the PICC had been discontinued.<br><br>During an interview on 12/15/11 at 8:50 a.m., the RN Nursing Consultant indicated there was no documentation of a Central line on the resident's readmission assessment on 09/28/11<br><br>During an interview on 12/15/11 at 2:45 p.m., the RN Nursing Consultant indicated she was not sure if the resident had a central line or a PICC line.<br><br>During an interview on 12/16/11 at 8:30 a.m., the RN Nursing Consultant indicated the resident was sent out to a vascular clinic on 10/21/11 and a central line was discontinued.<br><br>A progress note from the vascular clinic, received in the facility on 12/16/11 at 10:26 a.m. by fax, indicated the resident | | | |

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| | had a right IJ (interjugular) catheter removed. The progress note indicated the central line had been inserted six weeks ago for antibiotic therapy.<br><br>3. Resident #C's record was reviewed on 12/15/11 at 9:40 p.m. The resident's diagnoses included, but were not limited to dementia and hypertension.<br><br>A Progress Note, dated 12/04/11 at 8:12 p.m., indicated the resident fell, had full range of motion of the upper and lower extremities after the fall and the resident had not hit his head.<br><br>A Progress Note, dated 12/05/11 at 2:20 a.m., indicated the nurse had spoke to the hospital and the resident was being transferred back to the facility.<br><br>There was a lack of documentation in the resident's record to indicate the resident had been transferred to the hospital and the reason the resident had been transferred to the hospital.<br><br>During an interview on 12/16/11 at 8:40 a.m., the Director of Nursing indicated the Progress Notes did not say the resident went to the hospital and does not say why the resident went to the hospital. She indicated the nurse documented the information on the incident report (not a | | | |

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| | part of the resident's clinical record).<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | | |

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| R0035 | (j) Residents have the right to the following:<br>(1) Participate in the development of his or her service plan and in any updates of that service plan.<br>(2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.<br>(3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement.<br>(4) Refuse any treatment or service, including medication.<br>(5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility.<br>(6) Be afforded confidentiality of treatment.<br>(7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities. | | | |
| | Based on record review and interview, the facility failed to have residents participate in the development and updates of their service plans for 4 of 5 residents reviewed for service plan participation in a sample of 5. (Residents #101, #107. #110. and | R0035 | **R035**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged | 01/06/2012 |

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| | #113)<br><br>Findings include:<br><br>1. Resident #107's record was reviewed on 12/15/11 at 1:55 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and anemia.<br><br>The resident's undated, "Assessment & Service Plan", lacked documentation to indicate the resident participated in the development of the service plan.<br><br>2. Resident #101's record was reviewed on 12/15/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease.<br><br>The resident's, "Assessment & Service Plan", dated 08/24/11, lacked documentation to indicate the resident participated in the development of the service plan.<br><br>3. Resident #110's record was reviewed on 12//15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and bipolar.<br><br>The resident's, "Assessment & Service Plan", dated 08/31/11, lacked documentation to indicate the resident | | deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:** Assessment & Service Plans for Residents #101, 107, 110 and 113 were updated and reviewed with the residents on 12/15/11, including resident signature and date reviewed.<br><br>**2) How the facility identified other residents:** An audit of all Assessment & Service Plans was completed on 12/16/11 and all were updated and reviewed with residents, including resident signature and date reviewed.<br><br>**3) Measures put into place/ System changes:**<br><br>Assessment & Service Plans will be updated and reviewed with residents by the Director of Nursing or designee every 6 months.<br><br>The Medical Records Director will audit all Assessment & Service Plans within 72 hours of admission and every 6 | |

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| | participated in the development of the service plan.<br><br>4. Resident #113's record was reviewed on 12/15/11 at 1:40 p.m. The resident's diagnoses included, but were not limited to, osteomyelitis and anxiety.<br><br>The resident's, "Assessment & Service Plan", dated 08/31/11, lacked documentation to indicate the resident participated in the development of the service plan.<br><br>During an interview with the Director of Nursing, on 12/15/11 at 3:25 p.m., no further information was given. | | months to ensure completion and review has been completed with the resident.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in the monthly Quality Assurance Meeting for a minimum of 6 months to ensure compliance.<br><br>**5) Date of compliance: 1/6/12** | |

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| | 155572 | A. BUILDING 00<br>B. WING | 12/20/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN HILLS HEALTH AND REHAB CENTER | 10352 N 600 E COUNTY LINE RD<br>DEMOTTE, IN 46310 |

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| R0117 | (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.<br><br>Based on record review and interview, the facility failed to ensure there was at least one staff member with a current first aid and CPR (cardiopulmonary resuscitation) certificate scheduled for the day, evening, and night shift for all 3 shifts in 14 days of schedules.<br><br>Findings include:<br><br>Review of the nursing staff schedules, dated 12/05/11 through 12/18/11, received as current by the Director of | R0117 | **R117**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. | 01/06/2012 |

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| | Nursing (DoN), indicated there were no employees scheduled for duty who had both a CPR and a first aid certificate.<br><br>During an interview on 12/16/11 at 10 a.m., the DoN indicated she did not realize it was a requirement to have someone with CPR and first aid certified scheduled in the building. | | **1) Immediate actions taken:**<br>No residents were cited as affected.<br>An audit of all employee files was completed to identify staff members needing CPR and First Aid certification.<br><br>**2) How the facility identified residents affected:**<br><br>No residents were affected.<br><br>**3) Measures put into place/ System changes:**<br><br>Licensed nurses will complete CPR and First Aid certification training by 1/6/12, and any nurses hired after that date will be required to complete CPR and First Aid certification training within 90 days of hire date.<br><br>Human Resources Director or designee will audit all licensed nurse certification files monthly to ensure that certifications are complete and remain valid.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in the monthly | |

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| | | | Quality Assurance Meeting for a minimum of 6 months to ensure compliance.<br><br>**5) Date of compliance: 1/6/12** | |

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| R0148 | (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:<br>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.<br>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.<br>(3) All plumbing shall function properly and comply with state plumbing codes.<br>(4) At least yearly, heating and ventilating systems shall be inspected.<br><br>Based on observation, interview, and record review, the facility failed to ensure the facility was safe, clean and without odors, related to cigarette butts in the trash and a strong odor of cigarette smoke for 1 of 2 residents' rooms who smoke in a sample of 5. (Resident #101)<br><br>Findings include:<br><br>During an observation on 12/16/11 at 8:05 a.m., there was a strong cigarette smoke smell in the hall by Resident #101's room. The resident's waste basket, inside the room had several smoked cigarette butts in the plastic garbage bag.<br><br>During an interview at the time of the | R0148 | **R148**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>Cigarette butts were removed from Resident #101 trashcan. A smoking assessment was completed and a copy of the smoking policy was reviewed with | 01/06/2012 |

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| | observation, Housekeeper #5 indicated there was a smell of cigarette smoke at the door of the resident's room. She indicated there were several partial cigarette butts in the resident's waste basket.<br><br>During an interview on 12/16/11 at 8:10 a.m., the Director of Nursing acknowledged the cigarette butts in the waste basket. She stated, "guess we will have a chat with him today."<br><br>During an interview on 12/16/11 at 8:12 a.m., Resident #101 indicated he smokes in the facility's gazebo, but he brings the cigarette butts, after he puts them out, back into the facility and puts them in his waste basket.<br><br>Resident #101's record was reviewed on 12/15/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease.<br><br>The resident's Service Plan, dated 08/23/11, indicated the resident's judgement and memory was good and the resident makes sound decisions.<br><br>The resident's, "Smoking Safety Assessment", dated 02/25/11, indicated the resident demonstrated the ability to | | resident, including designated smoking areas and proper disposal of cigarette butts.<br><br>**2) How the facility identified other residents:**<br>7 residents were identified as smokers. A smoking assessment was completed for each resident and the smoking policy was reviewed with each resident.<br><br>**3) Measures put into place/ System changes:**<br><br>Housekeeping staff will randomly check trashcan in resident rooms during rounds at least 2 times per week and report any cigarette butts or strong cigarette odor in room to the Administrator.<br><br>**4) How the corrective actions will be monitored:**<br><br>Any issues identified during rounds will be addressed immediately and discussed in monthly Quality Assurance meetings for a minimum of 6 months.<br><br>**5) Date of compliance: 1/6/12** | |

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| | safely smoke without supervision.<br><br>A facility policy, dated 04/01/10, received as current from the Director of Nursing, titled, "Tobacco-Free Campus Policy", indicated, "...1. Staff will supervise resident smokers during designated smoking times...when timer goes off all items are to be extinguished and disposed of in the cigarette receptacle. No partially smoked cigarettes are to be saved..." | | | |

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| R0214 | (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. | | | |
| | Based on record review and interview, the facility failed to complete a pre-admission evaluation for a resident (#107) for 1 of 5 residents reviewed for individual needs assessments in a sample of 5.<br><br>Findings include:<br><br>Resident #107's record was reviewed on 12/15/11 at 1:55 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and anemia. The resident was admitted into the facility on 07/15/11.<br><br>There was a lack of documentation in the resident's record a pre-admission assessment had been completed on the resident prior to being admitted into the facility.<br><br>During an interview with the Director of Nursing, on 12/15/11 at 3:25 p.m., no further information was given in regard to the pre-admission assessment. | R0214 | **R214**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br>Pre-Admission assessment was completed for Resident #107.<br><br>**2) How the facility identified other residents:**<br><br>All resident files were audited to ensure Pre-Admission ssessments were completed. No other residents were affected.<br><br>**3) Measures put into place/ System changes:** | 01/06/2012 |

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| | | | Medical Records Director or designee will audit new admission charts within 72 hours of admission to ensure all required assessments and paperwork are completed and filed in charts.<br>Any deficiencies noted will be corrected immediately.<br>**4) How the corrective actions will be monitored:**<br>The results of these audits will be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months to ensure compliance.<br><br>**5) Date of compliance: 1/6/12** | |

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| R0216 | (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:<br>(1) The resident ' s physical, cognitive, and mental status.<br>(2) The resident ' s independence in the activities of daily living.<br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br>(4) If applicable, the resident ' s ability to self-administer medications.<br>(d) The evaluation shall be documented in writing and kept in the facility. | | | |
| | Based on record review and interview, the facility failed to complete a thorough needs assessment, related to a safe smoking assessment, for 1 of 2 residents who smoke in a sample of 5. (Resident #110)<br><br>Findings include:<br><br>Resident #110's record was reviewed on 12/15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and bipolar. The resident was readmitted into the facility on 01/13/11.<br><br>The resident's preadmission assessment, dated 01/10/11, indicated the resident smoked cigarettes.<br><br>There was a lack of documentation to indicate the resident was assessed for safe | R0216 | **R216**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br><br>As stated in the 2567, a Safe Smoking Assessment was completed for Resident #110 on 12/16/11.<br><br>**2) How the facility identified other residents:** | 01/06/2012 |

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| | smoking at the facility.<br><br>A, "Safe Smoking Assessment" form, received from the Director of Nursing on 12/16/11, indicated, "This assessment must be completed upon admission for ALL residents who wish to smoke..."<br><br>During an interview on 12/16/11 at 9:10 a.m., the Director of Nursing indicated an assessment had not been completed on the resident until 12/16/11. | | All residents identified as smokers have had a Safe Smoking Assessment completed.<br><br>**3) Measures put into place/ System changes:**<br><br>Social Services Director or designee will complete a Safe Smoking Assessment for residents identified as smokers upon admission, and every 6 months thereafter.<br><br>Medical Records Director or designee will audit new admission charts within 72 hours of admission to ensure all required assessments and paperwork are completed and filed in charts and every 6 months thereafter.<br>Any deficiencies noted will be corrected immediately.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months to ensure compliance.<br><br>**5) Date of compliance:** | |

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| R0217 | (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.<br>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. | | | |
| | Based on observation, record review and interview, the facility failed to update service plans for residents related to infection and isolation, self administration of medications, smoking, and an AV (arterio-venous) fistula (dialysis access) for 3 of 5 residents reviewed for service plans in a sample of 5. (Residents #101. #110, and #113) | R0217 | **R217**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations | 01/06/2012 |

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| | Findings include:<br><br>1. During an observation on 12/15/11 at 12:20 p.m., there was an isolation cart outside Resident #113's room.<br><br>Resident #113's record was reviewed on 12/15/11 at 1:40 p.m. The resident's diagnoses included, but were not limited to, osteomyelitis and anxiety.<br><br>A wound culture, dated 12/02/11, indicated the resident had methicillin resistant staph aureus in her left leg wound.<br><br>The resident's service plan, dated 08/31/11, lacked documentation to indicate the resident had an infection of the left leg wound and was in isolation.<br><br>During an interview on 12/15/11 at 1:55 p.m., LPN #6 indicated the resident was placed in isolation after the culture on 12/02/11.<br><br>2. Resident #101's record was reviewed on 12/15/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease.<br><br>a. The resident's, "Smoking Safety Assessment", dated 02/25/11, indicated | | and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Service Plans for Resident #113, #101, and #110 were updated to reflect current needs and status.<br><br>**2) How the facility identified other residents:**<br><br>All resident Service Plans were reviewed for accuracy and updated as indicated.<br><br>**3) Measures put into place/ System changes:**<br><br>Service Plan form has been revised to include a section “Temporary Service Issues” for short term acute issues identified.<br><br>Medical Records Director or designee will audit physician orders at least once per week and ensure Service Plans are updated as indicated with changes in plan of services.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will | |

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| | the resident demonstrated the ability to safely smoke without supervision.<br><br>b. An evaluation of the resident's ability to safely self-administer medication, dated 07/29/11, indicated, "...if the nurse reviewer determines that the resident is not capable of self-administering medications-Explain here...due to his hx (history) of alcoholism, this writer does not feel he is safe."<br><br>The resident's Medication Administration Record, dated 12/11, indicated the resident was self administering the medications.<br><br>The service plan, dated 08/24/11, indicated the resident requests staff to order medications, the resident will store and self-administer the medications, and the staff sets up the medications for the resident weekly.<br><br>The service plan, dated 08/24/11, lacked documentation to indicate the resident smokes cigarettes.<br><br>3. Resident #110's record was reviewed on 12//15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and bipolar.<br><br>An evaluation of the resident's ability to | | be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months.<br><br>**5) Date of compliance: 1/6/12** | |

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| | safely self-administer medication, dated 07/29/11, indicated, the resident could safely self-administer her medications.<br><br>Administration Record, dated 12/11, indicated the resident self-administers her medication after the staff sets up the medications weekly.<br><br>The service plan, dated 08/31/11, indicated, "...require staff to order, store and dispense medication(s)..."<br><br>The resident's physician's recapitulation orders, dated 11/11, indicated the resident had a left arm AV fistula.<br><br>There was a lack of documentation in the resident's service plan, dated 8/31/11, to indicate the resident had an AV fistula in her left arm.<br><br>During an interview on 12/16/11 at 9:10 a.m., the Director of Nursing indicated the AV fistula was not on the resident's service plan. | | | |

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| R0241 | (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides. | | | |
| | Based on observation, record review, and interview, the facility failed to administer medications as ordered by a resident's physician, related to not administering the correct dose of medications and omitting doses of medications for 1 of 5 residents observed during 1 of 5 observations of medication administration passes. (Resident #105)<br><br>Findings include:<br><br>During a medication administration pass observation, with RN #10 on 12/15/11 at 9:30 a.m., RN #10 prepared Resident #105's medication, which included, Allopurinal (medication for gout) 100 mg (milligrams), two tablets daily at 8 a.m., fish oil (supplement) 1,000 mg, four capsules daily at 8 a.m., and vitamin D (supplement) 50,000 units, one capsule two days per week at 8 a.m..<br><br>RN #10 removed the medication cards from the medication cart and placed one capsule of Allopurinal 100 mg, one capsule of fish oil 1000 mg, and one | R0241 | **R241 The facility is requesting paper compliance for this deficiency.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br>**1) Immediate actions taken for those residents identified:** Medication Error Reports were completed for Resident #105 and physician was notified. **2) How the facility identified other residents:** Medication Administration Records of all residents were reviewed since 12-1-11 and physicians notified as indicated. **2) Measures put into place/ System changes:** Medical Records Director or designee will audit Medication Administration Records weekly. The Director of Nursing will perform a random medication pass observation weekly on varied shifts. Issues identified will be addressed immediately. **4) How the corrective actions will be monitored:** The results of the audits will be reviewed in the monthly Quality Assurance | 01/06/2012 |

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| | capsule of Vitamin D in the plastic medication cup along with the resident's other medications. RN #10 administered the resident's medications at 9:35 a.m.<br><br>The Medication Administration Record (MAR), dated 12/11, indicated the resident had not received the Vitamin D since 12/01/11.<br><br>During an interview at the time of the observation, RN #10 indicated it looked like the resident had not received the Vitamin D in December of 2011.<br><br>During an interview on 12/15/11 at 10 a.m., RN #10 indicated she should have given two capsules of the Allopurinal and four capsules of the fish oil. She indicated the medications should have been given by 9 a.m. since they have an hour before or after to give the medications timely.<br><br>Review of the medication card for the Vitamin D 50,000 units, on 12/15/11 at 10 a.m., indicated the card was sent by pharmacy on 10/12/11 and the card had nine capsules in it. The card had seven capsules taken out of the card.<br><br>The resident's MAR, dated 10/11, indicated the resident received the Vitamin D on October 3, 5, 10, 12, 17, | | meeting for a minimum of 6 months. **5) Date of compliance: 1/6/12** | |

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| | 20, and 27, 2011 (seven doses).<br><br>The resident's MAR, dated 11/11, indicated the resident received the Vitamin D on November 3, 7, 10, 14, 17, 21, 24, and 28, 2011 (8 doses).<br><br>The resident's MAR, dated 12/11, had no initials on the record to indicate the resident had received the dosages as ordered on December 1, 5, 8, and 12, 2011.<br><br>During an interview on 12/16/11 at 8:45 a.m., the Director of Nursing indicated the Vitamin D was not being administered as ordered by the physician. She indicated the last medication card sent by the pharmacy was 10/02/11.<br><br>Resident #105's record was reviewed on 12/16/11 at 7:25 a.m. The resident's diagnosis included, but was not limited to, Dementia.<br><br>The resident's recapitulation physician's orders, dated 11/11, included physician orders for Allopurinal 100 mg, give two tablets daily at 8 a.m., fish oil 1,000 mg, give four capsules once daily at 8 a.m., and Vitamin D, 50,000 units, one capsule two days per week on Monday and Thursday at 8 a.m. | | | |

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| R0242 | (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. | | | |
| | Based on record review and interview, the facility failed to monitor effects of a resident's medication, related to not taking a blood pressure daily as ordered, prior to administering blood pressure medications, for 1 of 5 residents reviewed for medications in a sample of 5. (Resident #110)<br><br>Findings include:<br><br>Resident #110's record was reviewed on 12/15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and bipolar.<br><br>The physician's recapitulation orders, dated 11/11, indicated a physician's order for diltiazem ER (extended release) (blood pressure medication) 90 mg (milligrams), give two capsules daily at bedtime, 8 p.m., hold if systolic blood pressure is less than 100 and metoprolol (blood pressure medication) 100 mg, give one tablet two times a day, hold if systolic blood pressure is less than 100.<br><br>A Medication Administration Record | R0242 | **R242**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #110 no longer self-administers medication, physician was notified and blood pressure is checked daily.<br><br>**2) How the facility identified other residents:**<br><br>Audit was completed of Medication Administration Records, and physicians notified as needed.<br><br>**3) Measures put into** | 01/06/2012 |

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| | (MAR), dated 12/11, indicated the resident self-administers her medication after the staff sets up the medications weekly. The MAR indicated the diltiazem ER was scheduled for 8 p.m. The MAR indicated the metoprolol was scheduled for 9 a.m. and 5 p.m.<br><br>There was a lack of documentation on the resident's MAR to indicate resident's blood pressure was monitored prior to the resident taking the blood pressure medications or monitored daily.<br><br>There was a lack of documentation in the resident's Nurses' Notes to indicate the resident's blood pressure was monitored prior to taking the blood pressure medications or monitored daily.<br><br>During an interview on 12/16/11 at 9:10 a.m., the Director of Nursing indicated the nurses were taking the resident's blood pressure daily, and just not writing it down. She indicated she did not ask the nurses if they were taking the blood pressure daily, but that she has observed them taking a blood pressure. She indicated she is not in the facility seven days a week. | | **place/ System changes:**<br><br>Medical Records Director or designee will audit MAR's weekly.<br>The Director of Nursing will perform a random medication pass observation weekly on varied shifts.<br>Issues identified will be addressed immediately.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of the audits will be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months.<br><br>**5) Date of compliance: 1/6/12** | |

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| R0244 | (4) Preparation of doses for more than one (1) scheduled administration is not permitted.<br>Based on record review and interview, the facility failed to ensure not more than 1 scheduled medication administration was prepared related to the facility setting up medications for a week for 3 of 3 residents who self administer medications in a sample of 5. (Residents #101, #107, and #110)<br><br>Findings include:<br><br>1. Resident #110's record was reviewed on 12//15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and bipolar.<br><br>An evaluation of the resident's ability to safely self-administer medication, dated 07/29/11, indicated, the resident could safely self-administer her medications.<br><br>A Medication Administration Record, dated 12/11, indicated the resident self-administers her medication after the staff sets up the medications weekly.<br><br>2. Resident #101's record was reviewed on 12/15/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. | R0244 | **R244**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Residents #101, 107 and 110 no longer self-administer medications as of 12/16/11.<br><br>**2) How the facility identified other residents:**<br><br>No other residents self-administer pre-set medications.<br><br>**3) Measures put into place/ System changes:**<br><br>The facility no longer sets ups medications for residents to self administer. A licensed nurse or QMA administers medications when medications | 01/06/2012 |

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| | An evaluation of the resident's ability to safely self-administer medication, dated 07/29/11, indicated, "...if the nurse reviewer determines that the resident is not capable of self-administering medications-Explain here...due to his hx (history) of alcoholism, this writer does not feel he is safe."<br><br>The resident's Medication Administration Record, dated 12/11, indicated the resident was self administering the medications after staff set up his medications weekly.<br><br>3. Resident #107's record was reviewed on 12/15/11 at 1:55 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and anemia.<br><br>An evaluation of the resident's ability to safely self-administer medication, dated 07/29/11, indicated, the resident could safely self-administer her medications.<br><br>A Medication Administration Record, dated 12/11, indicated the resident self-administers his medication after the staff sets up the medications weekly.<br><br>During an interview on 12/15/11 at 12:35 p.m., LPN #6 indicated the night shift nurse sets up the resident's medications for a week in a medication cassette. | | are scheduled to be given.<br><br>The Director of Nursing will perform a random medication pass observation weekly on varied shifts to ensure medications are being administered by a licensed nurse or QMA.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months.<br><br>**5) Date of compliance: 1/6/12** | |

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| R0298 | (2) A consultant pharmacist shall be employed, or under contract, and shall:<br>(A) be responsible for the duties as specified in 856 IAC 1-7;<br>(B) review the drug handling and storage practices in the facility;<br>(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;<br>(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and<br>(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. | | | |
| | Based on record review and interview, the facility failed to ensure a consultant pharmacist reviewed a resident's drug regimen at least once every sixty days for 1 of 5 resident's reviewed for pharmacy recommendations in a sample of 5. (Resident #113)<br><br>Findings include:<br><br>Resident #113's record was reviewed on 12/15/11 at 1:40 p.m. The resident's diagnoses included, but were not limited to, osteomyelitis and anxiety. The resident was admitted into the facility on 07/15/05.<br><br>The facility staff were responsible for administering Resident #113's medications.<br><br>The resident's physician's recapitulation | R0298 | **R298**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>**The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.**<br><br>**1)** Immediate actions taken for those residents identified:<br><br>Unable to correct past deficiency cited for Resident #113.<br><br>2) How the facility identified other residents: | 01/06/2012 |

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| | orders, dated 06/11, indicated a consultant pharmacist reviewed the residents drug regimen on 06/03/11.<br><br>A Medication Regimen Review form, indicated the next pharmacy review was on 12/01/11.<br><br>During an interview on 12/16/11 at 9:10 a.m., the Director of Nursing indicated the resident had not had a pharmacy review every 60 days. | | All residents have the potential to be affected. Pharmacist has reviewed the medication regimen for all residents residing in the apartments. Pharmacist has documented her review in each medical record.<br>3) Measures put into place/ System changes:<br><br>Pharmacist will document medication review notes on a separate form in chart when the Physician Recapitulation orders are not available for signature.<br><br>4) How the corrective actions will be monitored:<br><br>Medical Records Director will audit records every 60 days to ensure pharmacist review is completed as required.<br>The results of these audits will be reviewed in monthly Quality Assurance meeting for a minimum of 6 months.<br><br>5) Date of compliance:<br>1/6/12 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| R0349 | (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:<br>(1) Complete.<br>(2) Accurately documented.<br>(3) Readily accessible.<br>(4) Systematically organized. | | | |
| | Based on record review and interview, the facility failed to ensure residents' records were complete and accurate related to service plans, weekly vital signs, and a mental health assessment for 3 of 5 resident's medical records reviewed in a sample of 5. (Residents #107, and #110)<br><br>Findings include:<br><br>1. Resident #107's record was reviewed on 12/15/11 at 1:55 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and anemia.<br><br>There was an undated and not signed Service/Functional Assessment in the resident's record.<br><br>The resident's Assessment & Service Plan was undated.<br><br>No further information was provided by the facility in regard to the resident's undated and unsigned forms in the record as of 12/15/11 at 3:25 p.m. | R0349 | **R349**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #107: The Service/Functional Assessment was signed and dated. Physician was notified of vital signs not documented on the dates identified.<br><br>Resident #110: A new mental health screen was completed to accurately reflect mood disorder.<br><br>**2) How the facility identified** | 01/06/2012 |

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|---|---|---|---|
| | 155572 | A. BUILDING 00<br>B. WING | 12/20/2011 |

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| | The physician's recapitulation orders, dated 11/11, indicated an order, dated 06/14/11, to obtain a full set of vital signs weekly on Tuesdays.<br><br>The resident's Medication Administration Record (MAR), dated 10/11, indicated the vital signs were not obtained on October 4, 18, and 25, 2011.<br><br>The resident's MAR, dated 12/11, indicated the vital signs were not obtained on 12/06/11.<br><br>During an interview on 12/16/11 at 9:40 a.m., the Director of Nursing indicated there were holes (blank spaces) on the MAR. She indicated the staff were not always documenting the vital signs.<br><br>2. Resident #110's record was reviewed on 12//15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and bipolar.<br><br>A mental health screening form, dated 01/13/11, indicated the resident did not have a diagnosed major mental illness. There was a check mark next to, "none". Mood disorder was not checked (bipolar).<br><br>During an interview on 12/16/11 at 11:40 a.m. the Social Service Director indicated | | **other residents:**<br><br>Medication Administration Records of all residents were reviewed and physicians notified as indicated.<br><br>All Service Functional Assessments were audited, no other residents were affected.<br><br>Social Service Director audited all mental health screens to ensure information was accurate.<br><br>**3) Measures put into place/ System changes:**<br><br>Medical Records Director or designee will audit Medication Administration Records at least once weekly.<br><br>Medical Records Director or designee will audit new admission charts within 72 hours of admission to ensure all required assessments and paperwork are completed and filed in charts and every 6 months thereafter.<br><br>Social Service Director will audit mental health screens upon admission and every 6 months to ensure | |

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| | mood disorder should have been checked. She indicated the resident was receiving mental health services. | | information is accurate.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months.<br><br>**5) Date of compliance: 1/6/12** | |

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| R0356 | (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:<br>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.<br>(2) The resident ' s hospital preference.<br>(3) The name and phone number of any legally authorized representative.<br>(4) The name and phone number of the resident ' s physician of record.<br>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.<br>(6) Information on any known allergies.<br>(7) A photograph (for identification of the resident).<br>(8) Copy of advance directives, if available. | | | |
| | Based on record review and interview, the facility failed to ensure an emergency information file was immediately accessible for 1 of 5 residents reviewed for emergency files in a sample of 5. (Resident #107)<br><br>Findings include:<br><br>Resident #107's record was reviewed on 12/15/11 at 1:55 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and anemia. The resident was admitted into the facility on 07/05/11.<br><br>The resident's record lack documentation to indicate the resident had an emergency | R0356 | **R356**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #107: Information required was placed in Emergency File. | 01/06/2012 |

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| | file.<br><br>The three ring binder, kept at the Nurses' Station, marked, "Emergency Files", lacked documentation to indicate the resident had an emergency file.<br><br>During an interview on 12/15/11 at 12:50 a.m., the Medical Records LPN indicated the resident did not have an emergency file. | | **2) How the facility identified other residents:**<br><br>An audit was completed of the Emergency File for all residents, and no other residents were affected.<br><br>**3) Measures put into place/ System changes:**<br><br>Medical Records Director or designee will audit the Emergency File within 72 hours for new admissions, and every 6 months thereafter to ensure required information is present and accurate.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months.<br><br>**5) Date of compliance: 1/6/12** | |

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| R0383 | (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following:<br>(1) Psychosocial rehabilitation services that are to be provided within the community.<br>(2) A comprehensive range of activities to meet multiple levels of need, including the following:<br>(A) Recreational and socialization activities.<br>(B) Social skills.<br>(C) Training, occupational, and work programs.<br>(D) Opportunities for progression into less restrictive and more independent living arrangements. | | | |
| | Based on record review and interview, the facility failed to develop a comprehensive careplan with the mental health service providers for 1 of 5 residents reviewed for mental health disease in a sample of 5. (Resident #110)<br><br>Findings include:<br><br>Resident #110's record was reviewed on 12//15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and bipolar.<br><br>A mental health screening form, dated 01/13/11, indicated the resident did not have a diagnosed major mental illness. There was a check mark next to, "none." Mood disorder was not checked (bipolar). | R0383 | **R383**<br>**The facility is requesting paper compliance for this deficiency.**<br><br>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #110: A new mental health screen was completed to accurately reflect mood disorder and a comprehensive care plan with the mental health service provider was placed in chart. | 01/06/2012 |

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| | The resident's service plan, dated 08/31/11, lacked documentation of a comprehensive careplan with the mental health service providers.<br><br>During an interview on 12/16/11 at 11:40 a.m., the Social Service Director indicated mood disorder should have been checked. She indicated the resident was receiving mental health services. She indicated there was not a mental health careplan in the resident's record.<br><br>During an interview on 12/16/11 at 12:35 p.m., the Social Service Director indicated she had the mental health service provider fax over a client evaluation/treatment plan. | | **2) How the facility identified other residents:**<br><br>Social Service Director audited all mental health screens to ensure information was accurate and that residents with a mental health disease have appropriate comprehensive mental health care plans in place.<br><br>**3) Measures put into place/ System changes:**<br><br>Social Service Director will audit mental health screens upon admission and every 6 months to ensure information is accurate and that appropriate comprehensive mental health care plan is in place.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in the monthly Quality Assurance meeting for a minimum of 6 months.<br><br>**5) Date of compliance: 1/6/12** | |